STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Desoto	3068 Nail Road West Horn Lake, MS 38637

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review and facility policy review the facility failed to ensure informed consent was obtained prior to the initiation of psychotropic medications for 5 (five) of 5 residents reviewed for unnecessary medications. Resident #1, Resident #3, Resident #6, Resident #12, and Resident #38. Findings Include: Facility policy titled Psychotropic Medications, dated 02/25, stated, Consent for Anti-psychotic Medication Treatment shall be completed for new order of or increasing the dose of an anti-psychotic, psychoactive, or neuroleptic medication. The prescribing physician, or facility medical director shall complete Section I providing indications for use, diagnosis, risks, benefits, alternatives and course of therapy. Section II shall be completed by resident or resident representative. Resident #1 Record review of Resident #1's Order Summary Report revealed an order dated 2/13/26, Klonopin (anti-anxiety) 0.5 MG (milligram) oral tablet (Clonazepam) give 1 (one) tablet via PEG (percutaneous endoscopic gastrostomy) Tube every 8 (eight) hours as needed for agitation and combativeness. Further review revealed an order dated 1/29/26, Risperdal (antipsychotic) oral tablet give 1 (one) tablet via PEG-Tube two (2) times a day related to Generalized Anxiety Disorder. Record review of Resident #1's Consent for Anti-psychotic, Psychoactive or Neuroleptic Medication Treatment revealed a phone consent was obtained for Klonopin and Risperdal by the resident representative (RR) on 2/14/26, after the medications were initiated. Record review of the Face Sheet revealed the facility admitted Resident #1 on 1/28/26 with medical diagnoses including Encounter for Attention to Gastrostomy and Generalized Anxiety Disorder. Record review of the MDS with an ARD of 2/4/26 revealed under section C, a Staff Assessment for Mental Status indicated Resident #1's cognitive skills for daily decision making were moderately impaired. Resident #3 Record review of Resident #3's Order Summary Report revealed an order dated 10/13/25 for Mirtazapine Tablet 7.5 MG Give 1 tablet by mouth in the evening for depression. There was also an order dated 11/05/25 for Trazodone HCL (Hydrochloride) Oral Tablet 50 MG Give 25mg by mouth every 12 hours as needed for anxiety related to Dementia Record review of Order Summary Report also revealed an order dated 03/18/26 with an end date of 03/29/26 for Risperdal Oral Tablet 0.5MG (Risperidone) Give 1 (one) tablet every 8 hours as needed for behavioral disturbances related to (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	255281	A. Building B. Wing	03/19/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dementia . Record review of Resident #3's Consent for Anti-psychotic, Psychoactive or Neuroleptic Medication Treatment form revealed that the Resident Representative consented by phone on 03/19/26 for the Mirtazapine which was ordered on 10/13/25, for the Trazodone which was ordered on 11/05/25, and for the Risperdal which was ordered on 03/18/26. During an interview on 03/19/26 at 9:10 AM with Director of Nursing (DON), she confirmed that Resident #3's Consent for Anti-psychotic, Psychoactive or Neuroleptic Medication Treatment form was signed after she started taking the Mirtazapine, Trazodone, and the Risperdal. She further revealed that the medications should have been explained to the resident and/or family initially prior to administration and that they would get their process corrected. Record review of Resident #3's Face Sheet revealed an admission date of 10/01/25 and that she had diagnoses that included Dementia and Encephalopathy. Record review of Resident #3's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/13/26 under Section C - Cognitive Patterns revealed a Brief Interview for Mental Status (BIMS) Score of 06 which indicated that she had severe cognitive deficits. Resident #6 Record review of the Order Summary Report dated 3/19/2026 revealed active medication orders for Lorazepam Oral Tablet 0.5 milligram (mg), start date 8/15/2025; Donepezil HCl Tablet 10 mg, start date 10/2/2025; and Olanzapine Oral Tablet 2.5 mg, start date 10/2/2025. Record review of the Consent for Antipsychotic, Psychoactive or Neuroleptic Medication Treatment form revealed consent for Olanzapine 2.5mg daily, Donepezil 10 mg, and Lorazepam was signed by the provider 1/27/26 and obtained via telephone from the resident representative (RR) also on 1/27/2026. During an interview on 3/18/2026 at 2:20 PM, the DON stated the consent form dated 1/27/26 was the only consent form available. She stated, I got to it as soon as I could. I tried to get the Medical Director to complete them when the regulations changed. He did a few of them and then said he couldn't do them, gave his 30-day notice and never came back.Record review of the Face Sheet indicated Resident #6 was admitted to the facility on [DATE] with medical diagnoses that included senile degeneration of brain, dementia and bipolar disorder. A record review of the MDS with an ARD of 2/25/26, revealed under section C that a BIMS was not conducted because the resident was rarely or never understood. Resident #12 Record review of Resident #12's Order Summary Report revealed an order with start date of 11/04/25 for Haloperidol Decanoate IM (Intramuscular) Solution 50 MG/ML to inject 50 mgs intramuscular one time a day starting on the 14th every month related to Schizophrenia, unspecified. Record review of Resident #12's Consent for Anti-psychotic, Psychoactive or Neuroleptic Medication Treatment form revealed that the Resident Representative signed the form on 12/18/25 which was after the Anti-psychotic medication, Haloperidol Decanoate, was initiated. An interview on 03/19/26 at 9:07 AM with DON, revealed that she initially completed the consents for (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	antipsychotic medications, but due to increased workload, she asked the medical director to complete them during his rounds. She revealed that due to the lengthy process, the Medical Director requested that she complete the consent forms for him to sign. DON confirmed that Resident #12's consent was signed after starting the Haldol medication and further revealed that the medication should have been explained to the resident and/or family first. Record review of Resident #12's Face Sheet revealed an admission date of 02/10/25 and that she had diagnoses that included Unspecified Dementia and Schizophrenia. Record review of Resident #12's MDS with ARD of 02/18/26 under Section C - Cognitive Patterns revealed a BIMS score of 15 which indicated that she had no cognitive deficits. Resident #38 Record review of Resident #38's Order Summary Report revealed an order dated 7/15/24, Duloxetine (antidepressant) 30 MG give 1 (one) tablet orally two times a day related to Major Depressive Disorder. Record review of Resident #38's Consent for Anti-psychotic, Psychoactive or Neuroleptic Medication Treatment revealed the resident signed the consent acknowledging the risks and benefits of the drug Duloxetine on 1/27/26, which was not completed timely for informed consent. An interview with the DON on 3/19/26 at 9:18 AM revealed she initially completed the psychotropic consents; however, due to workload, she requested the medical director complete them during resident visits. She stated the medical director verbalized the process took too long and requested that she complete the consents for him to sign. She confirmed the consents were not provided to the resident and/or families in advance of treatment and therefore did not represent true informed consent. Record review of the Face Sheet revealed the facility admitted Resident #38 on 8/29/22 with medical diagnoses that included major depressive disorder, recurrent. Record review of the MDS with an ARD of 12/29/25 revealed under section C, a BIMS summary score of 15, indicating Resident #38 was cognitively intact.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to ensure that the physician reviewed and responded to pharmacy recommendations for gradual dose reduction (GDR) and failed to ensure as-needed (PRN) psychotropic medication orders included a stop date for four (4) of five (5) residents. (Residents #1, #6, #12, and #38) Findings Include: Review of the facility policy Gradual Dose Reduction (GDR) for Psychotropic Medications with revision date of 11/17 revealed A Gradual Dose Reduction (GDR) is a stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. Within 1st (first) year after admission on psychotropic or after initiation: GDR in 2 (two) separate quarters, with at least one month between attempts. After 1st (first) year GDR annually Review of facility policy titled Psychotropic Medications with review date 2/2025, revealed, .as needed (PRN) orders for psychotropic medications will be limited to 14 days unless the physician identifies the rationale to extend the medication beyond 14 days. PRN anti-psychotic drugs will be limited to 14 days and will not be renewed unless the physician evaluates the resident for appropriateness of the medication.The facility shall implement gradual dose reductions (GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication. Resident #1 Record review of Resident #1's Order Summary Report revealed an order dated 2/13/26, Klonopin (anti-anxiety) 0.5 MG (milligram) oral tablet (Clonazepam) give 1 (one) tablet via PEG (percutaneous endoscopic gastrostomy) Tube every 8 (eight) hours as needed for agitation and combativeness without a stop date. An interview with the Pharmacy Consultant on 3/18/26 at 2:20 PM revealed he was aware that Resident #1 was ordered PRN (as needed) klonopin without a stop date and stated he had sent a notification to the provider the previous month. He confirmed the PRN order remained unaddressed. An interview with the Director of Nursing (DON) on 3/18/26 at 2:32 PM confirmed Resident #1's as needed Klonopin order should have had a stop date after 14 days and then be re-evaluated for continued need. Record review of the Face Sheet revealed the facility admitted Resident #1 on 1/28/26 with medical diagnoses including Encounter for Attention to Gastrostomy and Generalized Anxiety Disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/4/26 revealed under section C, a Staff Assessment for Mental Status indicated Resident #1's cognitive skills for daily decision making was moderately impaired. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6 Record review of Resident #6's March Medication Administration Record (MAR) revealed a physician order for Lorazepam Oral Concentrate 1 milligram (mg)/0.5 milliliter (mL), give 0.5 mL by mouth every two (2) hours as needed for anxiety, with a start date 8/13/2025; however, the order did not have a stop date. Record review of Resident #6's March MAR revealed a physician order for Lorazepam Oral Concentrate 2 milligram/milliliter, give 1 mL by mouth every two (2) hours as needed for anxiety, with a start date 8/13/2025; however, the order did not have a stop date. During an interview on 3/18/2026 at 2:20 PM, the DON confirmed the two (2) as needed (PRN) Lorazepam orders did not have a stop date. She stated the hospice nurse and the resident's family did not want the medication discontinued. Review of a pharmacy recommendation related to Ativan 0.5 mg daily, dated 2/23/2026, revealed no evidence the physician reviewed the recommendation. Review of the admission Record indicated Resident #6 was admitted to the facility on [DATE] with a medical diagnosis that included senile degeneration of brain, dementia and bipolar disorder. A review of the MDS with an ARD of 2/25/26, revealed under section C that a BIMS was not conducted because the resident was rarely or never understood. Resident #12 During an interview on 03/19/26 at 9:07 AM with DON, she revealed that the facility's psychiatrist was the one responsible for completing the GDR's and addressing the recommendations. She revealed that their psychiatrist quit about three months ago and now the Medical Director was responsible. DON revealed that the medical director currently had the pharmacist recommendations in his folder, but none had been addressed nor returned to them. She confirmed that the purpose of the GDR's was to ensure residents' medications were maintained on the lowest effective dose possible. Record review of Resident #12's Pharmaceutical Consultant Report revealed that the last completed Psychoactive GDR was dated 02/11/25. Record review of Resident #12's Consultant Pharmacist Recommendation dated 12/29/25 revealed that notices were sent to the provider to consider dose reductions for Trazodone and Haldol and they were not addressed. Record review of Resident #12's Order Summary Report revealed an order dated 01/17/23 for Trazodone HCL (hydrochloride) 25mg (milligrams) for 1 tablet by mouth at bedtime and an order dated 11/04/25 for Haloperidol Decanoate IM (Intramuscular) Solution 50mg (milligrams)/ml (milliliter) to inject 50mg intramuscularly one time a day starting on the 14th every month and ending on the 14th every month related to Schizophrenia. Record review of Resident #12's Face Sheet revealed an admission date of 04/18/19 and that she had diagnoses that included Unspecified Dementia, Anxiety, and Schizophrenia. Record review of Resident #12's MDS with ARD of 02/18/26 under Section C - Cognitive Patterns revealed a BIMS Score of 15 which indicated that she was cognitively intact. Resident #38 Record review of Resident #38's Order Summary Report revealed an order dated 7/15/24, Duloxetine (antidepressant) 30 MG give 1 (one) tablet orally two times a day related to Major Depressive (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Disorder. Record review of the Consultant Pharmacist Recommendation dated 12/29/25 revealed a notice was sent to the provider to consider a dose reduction for duloxetine 30 mg which remained unaddressed. An interview with the DON on 3/18/26 at 2:32 PM revealed the facility's psychiatrist quit in December 2025 without notice, and at that time he was responsible for completing the GDR's and addressing the pharmacist recommendations. She revealed the medical director currently had the pharmacist recommendations in his folder; however, none had been signed or addressed. She confirmed the purpose of the GDR's was to ensure residents were maintained on the lowest effective dose and to prevent overmedication. Record review of the Face Sheet revealed the facility admitted Resident #38 on 8/29/22 with medical diagnoses that included major depressive disorder, recurrent. Record review of the MDS with an ARD of 12/29/25 revealed under section C, a BIMS summary score of 15, indicating Resident #38 was cognitively intact.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, staff interview, record review and facility policy review, the facility failed to ensure the medication error rate was five (5) percent (%) or less for six (6) of thirty-three medication opportunities. Medication error rate of 18.18%.Findings Include: Review of the facility policy titled Administration of Medications revised 3/25 revealed under, Procedure . 3. Drugs and biologics are administered no more than one hour before or no more than one hour after the dosage time on the order. Also revealed under, Oral Medication Administration Procedure: . 3. Verify the physicians order, comparing the medication label to the MAR (Medication Administration Record) to verify the following:a. Right medicationb. Right dosagec. Right routed. Right timee. Right resident. Record review of Resident #17's Medication Administration Record (MAR) revealed the following medications were scheduled for administration at 9:00 AM: Lisinopril 10 milligrams (hypertension), Multivitamin liquid (supplement), Hydroxyzine 10 milligrams (anxiety), Metformin 500 milligrams (diabetes), and Levetiracetam solution 12 milliliters (epilepsy). An interview on 3/18/26 at 7:35 AM with Licensed Practical Nurse (LPN) #1 revealed she had already administered Resident #17's 9 AM medications. She acknowledged she gave the medications early, identified this as a medication error, and confirmed this did not follow nursing standards of practice for medication administration. She confirmed medications could only be given one hour before and one hour after the scheduled time. During an observation of med pass on 3/18/26 at 8:03 AM, LPN #1 prepared Resident #43's medications and stated the resident was out of prednisone 5 milligram tablets. The medication was not administered. LPN #1 stated she would write the medication down on her list to be faxed to the pharmacy and re-ordered, confirming the medication would not be available today. Record review of Resident #43's MAR revealed an order dated 1/21/26, Prednisone oral tablet give 1 (one) tablet by mouth one time a day related to Bronchitis due at 8 AM. A follow up interview with LPN #1 on 3/18/26 at 10:32 AM revealed Resident #43's prednisone was still not available. She confirmed the resident could have respiratory changes by missing a dose. Review of the facility's Total Medication Error Rate following reconciliation indicated the medication error rate was 18.18 % (percent). An interview with the Director of Nursing (DON) on 3/18/26 at 1:45 PM stated that prednisone was a medication that was kept in the emergency drug kit in the medication room. She stated she was not notified that Resident #43 was out of prednisone and stated if the medication was not in the emergency kit, the order still could have been faxed to the pharmacy, and they would have called it in to the backup pharmacy. The DON confirmed the resident should not miss a dose of medication and acknowledged medications were to be given 1 hour before or 1 hour after the scheduled time, confirming the med errors and of which could cause unwanted side effects. Record review of the Face Sheet revealed the facility admitted Resident #17 on 7/27/22 with medical diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/20/26 revealed under section C, a Staff Assessment for Mental Status indicated Resident #17's cognitive skills for daily decision making were severely impaired. Record review of Resident #43's Diagnoses List revealed the facility admitted the resident on 1/20/26 with medical diagnoses including Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation and Bronchitis. Record review of the MDS with an ARD of 1/27/26 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #43 was cognitively intact.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, record review, and facility policy review, the facility failed to have the call light accessible for Resident #30, this was for one (1) of 24 residents reviewed. Findings Include:Review of facility policy titled, Resident Call Light System, dated 07/25, revealed, A call light system is in place and operative in facility. This system allows individual residents to access a system that notifies nursing that the resident has a need . An observation and interview on 03/17/2026 at 10:50 AM observed Resident #30 lying in her bed and alert to name being called. A fall mat was on the floor next to the bed with bed in the lowest position. Observed a sign above the bed reminding resident to call for assistance, Please call, don't fall. Use the call button for assistance. Observed that call light was not within reach. Interview with the resident at that same time, asked if she knew what to do if she needed help and resident stated, I push the red button. Interview and observation on 03/17/26 at 10:56 AM with Licensed Practical Nurse (LPN) #2 stated resident is a fall risk, and she recently returned from hospital stay for a Urinary tract infection (UTI). LPN #2 walked into room and confirmed that Resident #30's call light was not easily accessible for the resident, and it should be. The call light was observed between the bed and the wall and was not reachable by the resident. Interview and observation on 3/17/26 at 1:04 PM with Certified Nursing Assistant (CNA) #1 confirmed that the call light should be within reach for the resident. She stated that the call light got dislodged with care this morning and she did not place it back in reach for the resident. Record review of the Face Sheet revealed the facility admitted Resident #30 on 3/24/25 with diagnoses that included chronic obstructive pulmonary disease.Record review of the Minimum Data Set with an Assessment Reference Date of 12/10/25 revealed a Brief Interview for Mental Status score of 09 which indicated moderately impaired cognition.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the accuracy of resident assessments by inaccurately completing section H (bowel and bladder) of the Minimum Data Set (MDS) for one (1) of 18 sampled residents. Resident #11.Findings Include: Review of the facility policy titled Resident Assessment, revised 9/19, revealed, An assessment will be completed on each resident utilizing the MDS (Minimum Data Set). The reason for the assessment, schedule, and timeframes will be according to the guidance of the Resident Assessment Instrument (RAI) Manual. An observation conducted on 3/17/26 at 11:29 AM revealed Resident #11 lying in bed with a urinary catheter drainage bag attached to the lower portion of the bed frame. Record review of Resident #11's Quarterly MDS with an Assessment Reference Date (ARD) of 12/19/25 revealed under Section H (Bladder and Bowel), item H0100 an indwelling catheter was not indicated. Record review of Resident #11's December Treatment Administration Record (TAR) revealed an order dated 7/7/25, Change catheter and catheter bag monthly and PRN (as needed). An interview with the MDS Nurse on 3/19/26 at 8:17 AM confirmed an error was made on December 2025 MDS and did not capture Resident #11's indwelling catheter. She stated the MDS should be accurate to ensure appropriate care was provided to the resident. Record review of the Face Sheet revealed the facility admitted Resident #11 on 7/2/25 with medical diagnoses including Diverticulosis of Intestine without Perforation and Pressure Ulcer of Sacral Region, Stage 3. Record review of the MDS with an ARD of 3/13/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #11 was cognitively intact.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and facility policy review, the facility failed to ensure the interdisciplinary team (IDT) reviewed and revised the resident's comprehensive care plan to reflect changes in the resident's condition for one (1) of eighteen (18) residents reviewed. (Resident #18)Findings include:Review of facility policy titled Care Plan Process with review date 3/26, revealed, Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to several specified areas.The comprehensive care plan is an interdisciplinary communication tool. The IDT will minimally include the attending physician, Registered Nurse (RN) with responsibility for the care of the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, the resident and the resident's representative (s) to the extent practicable, and any other disciplines as appropriate such as social services, activities, therapy, etc.The care plan must be reviewed and revised periodically, on an ongoing basis to reflect the services provided or arranged and must be consistent with each resident's written plan of care. The facility shall use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care.Record review of Care Plan Review forms dated 3/13/2026, 12/16/2025, and 9/26/2025 revealed the Social Services Director was the only member of the Interdisciplinary Team (IDT) to sign the form for these meetings. The forms indicated the Resident Representative attended via telephone. Record review of Progress Notes dated 9/25/2025, revealed, contact (responsible party legal name) for scheduled care plan. No response.During an interview on 03/19/2026 at 9:00 AM, the Minimum Data Set (MDS) Coordinator and MDS Nurse stated the MDS team develops the assessment calendar and provides it to the Social Worker (SW), who schedules care plan meetings with the resident and/or resident representative either in person or by telephone. They stated the IDT includes MDS nurses, therapy, Social Services, Activities, and Dietary, and that care plan meetings are conducted quarterly in conjunction with MDS assessments. The MDS Nurse stated the SW is responsible for ensuring care plan meetings are conducted and that IDT members sign the Care Plan Review form during the meetings to document attendance. During an interview on 03/19/2026 at 9:10 AM, the Administrator confirmed the Social Worker invites the resident and/or resident representative and that care plan meetings are held on Tuesdays, Thursdays, and as needed. She stated the IDT meets and the SW documents the meetings. Regarding Resident #18, the Administrator stated the resident was cognitively and physically able to participate in care plan meetings and be involved in her care. She further stated her expectation was for facility policy to be followed and for residents to be involved in their care to the extent possible. Record review of the admission Record indicated Resident #18 was admitted to the facility on [DATE] with medical diagnoses that included End Stage Renal Disease.A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/4/26, revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #18 was cognitively intact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255281	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Desoto	3068 Nail Road West Horn Lake, MS 38637

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, record review, and facility policy review the facility failed to provide services to maintain or improve range of motion by not ensuring a physician ordered splint was applied daily for 1 (one) of 2 (two) residents reviewed. Resident #17. Findings Included:Record review of the facility policy Range of Motion with revision date of 01/24, revealed that the purpose was To improve or maintain joint mobility and muscle strength and To prevent contractures Observations on 03/17/25 at 10:55 AM and on 03/18/26 at 8:15 AM revealed Resident #17 lying in bed, he was non-verbal with his eyes open. His right hand was contracted and there was no wrist splint device in place. It was observed that there was a hand splint on the seat of the wheelchair that was against the wall. An interview and observation on 03/18/26 at 1:50 PM with Registered Nurse (RN) #1, revealed that they only had one resident requiring hand splints in the facility. She revealed that Resident #17 had received therapy services in the past and they had put a hand splint on him but since he had been discharged from them, he did not wear one. An observation with RN #1 in Resident # 17's room confirmed that there was a hand splint in his wheelchair in the corner of the room and his name was written on it. She stated, I don't know why that is in here, I've never put a hand splint on him. RN #1 confirmed that his right hand was contracted. She revealed that she wasn't aware there was an order for a splint to be put on, further stating that there wasn't anything on his MAR (Medication Administration Record) or TAR (Treatment Administration Record) to indicate that he needed to wear the splint every day. RN #1 revealed that not wearing a hand splint could cause the contracture to get worse. An interview on 03/18/26 at 2:15 PM with Director of Nursing, revealed that Resident #17 was supposed to wear a hand splint for four hours every day. DON viewed and confirmed the order for the hand splint to be placed for four hours a day and stated she didn't realize it wasn't getting done. She also reviewed Resident #17's TAR and confirmed the order was not put in correctly and it did not carry over for the nurses to know to do it. DON revealed that by not applying the hand splint daily as ordered, it could result in worsening of the contracture. An interview on 03/18/26 at 2:30 PM with Director of Rehab revealed that they had worked with Resident #17 in the past on stretching exercises to see if he would be able to straighten out his hand. She revealed that back in the summer of 2025, they ordered him and other residents hand splints, and they started putting the splint on Resident #17 for four hours a day. She revealed that they also educated the nurses and the nurses were applying the splint, and it was their responsibility to ensure it was on. Director of Rehab revealed that failure to apply the hand splint daily as ordered could result in the contracture worsening. Record review of Resident #17's Order Listing Report revealed an order dated 05/26/25 to apply right wrist splint for 4 hours per day. 2-hour skin checks under splint/brace for redness irritation, swelling, breakdown and adequate circulation/sensation prn (as needed) while splint in place every day shift for contracture prevention. Record review of Resident #17's March 2026 TAR revealed no order to apply the wrist splint every day. Record review of Resident #17's Face Sheet revealed an admission date of 07/27/22 and that he had diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side and Contracture of Right Hand.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure proper positioning and management of an indwelling urinary catheter drainage system for one (1) of one (1) resident reviewed for urinary catheter. Resident #11 Findings Include: Review of the facility policy titled Perineal Care, revised 1/24, revealed under Resident with Catheter: . 7. Ensure tubing is not positioned above the level of the bladder.An observation conducted on 3/17/26 at 11:29 AM revealed Resident #11 lying in bed with a urinary catheter drainage bag attached to the lower portion of the bed frame.Record review of Resident #11's Order Summary Report revealed an order dated 7/3/25, Foley catheter care Q (every) shift and PRN (as needed).During an observation of catheter care provided to Resident #11 by Certified Nurse Aide (CNA) #1 and Registered Nurse (RN) #1 on 3/18/26 at 11:00 AM, the urinary drainage bag was removed from the lower bed frame and placed in the bed with the resident during catheter care. This positioning resulted in urinary backflow from the drainage bag into the tubing.An interview with RN #1 on 3/18/26 at 11:12 AM confirmed the urinary drainage bag was not positioned appropriately to allow for proper drainage during catheter care and stated the urine could reflux and increase the risk for a urinary tract infection.Record review of the Face Sheet revealed the facility admitted Resident #11 on 7/2/25 with medical diagnoses including Diverticulosis of Intestine without Perforation and Pressure Ulcer of Sacral Region, Stage 3.Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/13/26 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 15, indicating Resident #11 was cognitively intact.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure insulins were properly stored in accordance with manufacturer's guidelines to maintain safety and effectiveness for one (1) of two (2) medication carts observed. 300 hall Findings Include:Review of the facility policy titled Medication Storage, revised 11/17, revealed, Storage, supplies and equipment necessary for appropriate temperatures and conditions per the manufacturer's specifications.An observation of the 300 hall medication cart on 3/18/26 at 9:45 AM, with Licensed Practical Nurse (LPN) #1, revealed the following insulins were in use and either exceeded the manufacturer's 28-day room temperature storage limit or were not dated when opened:Resident #2 - Open vial of Novolog that was undated.Resident #3 - Open vial of Humalog dated 12/23/25.Resident #17 - Open vial of Insulin Aspart that was undated.Resident #51 - Humalog KwikPen that was undated. Record review of the manufacturer's storage instructions for Humalog and Novolog (Insulin Aspart) revealed that once opened, these insulins may be stored at room temperature for up to 28 days, after which the product should be discarded.An interview with LPN #1 on 3/18/26 at 9:52 AM revealed that if insulin did not have an open date, there would be no way to determine if the insulin was still safe to administer. She stated that insulin was good for 90 days after removal from refrigeration. LPN #1 confirmed that out-of-date insulin would not be as effective and could result in residents' blood glucose not being controlled.An interview with the Director of Nursing on 3/19/26 at 8:32 AM revealed that insulins stored on medication carts should be checked by nursing staff to ensure they are labeled with an open date and are not beyond the 28-day use period, after which they should be discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, record review and facility policy review the facility failed to properly disinfect a glucometer after use, in accordance with infection control standards during one (1) of 6 (six) medication administration passes observed and failed to ensure contact precautions were in place for one (1) of five (5) residents reviewed for infection control. Resident #30.Findings Included: Review of the facility policy Infection Control Policy for General Cleaning and Maintenance of Equipment with revision date of 02/26 revealed that .Critical and invasive resident care devices (e.g. (exempli gratia), glucometers) shall be cleaned and disinfected per manufacturers' recommendations Record Review of Policy for Control of Multidrug-Resistant Organism (MDRO) Infection,latest review date 08/21 revealed, It is the policy of this facility to place residents in contact and/or droplet precautions if they are displaying symptoms of active multidrug-resistant organism (MDRO) infection An infection is considered to be active when MDROs enter the body and multiply in tissues, causing clinical manifestation of disease and immune response . An observation on 03/18/2026 at 11:05 AM revealed that Licensed Practical Nurse (LPN) #1, failed to clean and disinfect a glucometer correctly after exiting room [ROOM NUMBER]. She used a Micro Kill Two wipe, she wiped down the front and back of the glucometer and placed it immediately back inside the storage pouch. An interview on 03/18/26 at 11:08 AM with LPN #1, revealed that she always cleaned the glucometers after use. She revealed that she cleaned the glucometer on front and back and left the machine open to air until it was dry before she placed it back in the drawer. She revealed that she was not aware that she must leave the glucometer wet for 2 (two) minutes and that she cleaned it the way she was taught in nursing school. LPN #1 revealed that the purpose of correctly cleaning glucometers was to prevent cross contamination and the possible spread of infection. An interview on 03/18/26 at 2:00 PM with Director of Nursing (DON), revealed that the nurses were supposed to clean the glucometers following each use. She revealed that they were supposed to clean the glucometer front and back and then wrap it up with the wipe for at least two minutes prior to storing it. She revealed that not cleaning the glucometer correctly could cause the spread of infection including blood borne pathogens. Record review of the Manufacturer Instructions for the micro-kill two germicidal wipes revealed that it disinfects hard, nonporous surfaces in 2 (two) minutes. Instructions for use revealed, If present, use a wipe to remove visible soil prior to disinfecting. Unfold a clean wipe and thoroughly wet surface. Allow surface to remain visibly wet for contact time(s) listed on the label . Resident #30 Record review revealed a urine culture was obtained for Resident #30 on 02/24/2026 and lab reported on 03/01/2026 with culture results of Extended-Spectrum Beta-Lactamase-Producing (ESBL). Interview on 03/18/26 at 2:01 PM with the DON stated, I don't remember an ESBL diagnosis, but I'll go check. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/18/26 at 2:45 PM with LPN #2 verified that the resident was diagnosed with ESBL according to the 03/01/2026 lab report, but she confirmed that she was unaware that the resident had this diagnosis and confirmed that the resident was not on contact precautions. Interview on 03/18/26 at 3:09 PM the DON confirmed Resident #30's lab results and stated, When I looked at the lab results, I didn't see the ESBL. I did miss that. DON confirmed that resident should be on contact precautions, but precautions were not initiated. Interview on 03/19/26 at 9:50 AM with the DON stated she has been doing the Infection Prevention (IP) role for about six (6)-eight (8) months after the nurse left and stated I don't know what they would do if I was out. I'm the only one with IP certification and I have voiced my concerns. Record review of the Face Sheet revealed the facility admitted Resident #30 on 3/24/25 with diagnoses that included Chronic Obstructive Pulmonary Disease.